Consumer Protections: Ensuring Beneficiary Control and Choice

Duals Demonstration Stakeholder Meeting
December 12, 2011

Introduction

- The following are sample consumer protections extracted from various documents, including:
  - The SPD Section of the 1115 Waiver (Waiver)
  - Health Risk Assessments Waiver Addendum (Addendum)
  - Memorandum of Understanding included in the CMS July 8 Letter to State Medicaid Directors on Financial Models for the Duals Demo (MOU)
  - CMS Standards and Conditions that will apply to the state proposal (Standards)
  - Consumer Protections Framework drafted by Harbage Consulting and circulated this fall (Framework)
  - National Senior Citizens Law Center's Issue Brief on Consumer Protections (NSCLS)
- These are NOT recommended protections for the duals demonstration; rather they are a starting point for an in-depth discussion.

Outline

1. Ensuring Proper Care

- Appropriate/Accessible Care
- Beneficiary-Centered Care Models
- Adequate Care Coordination
- Seamless Transitions

2. Creating Effective Two-Way Site-Beneficiary Communication

- Meaningful Notice
- Accessible Communications

3. Ensuring Proper Access and Delivery

- Network Adequacy
- Oversight/Monitoring
- Appeals
- Benefit Package

4. Launching the System

- Enrollment
- Assessment
- Transition

Ensuring Proper Care

Appropriate & Accessible Care

- The State "will ensure that all care meets the beneficiary's needs, allows for involvement of caregivers, and is in an appropriate setting, including in the home and community" (Standards, NSCLC).
- "Dual eligibles in integrated models have a right to receive services, including notices, in a culturally appropriate manner, accounting for their race, ethnicity, language, sex, disability, sexual orientation and gender identity" (NSCLC).
- Coordinated care delivery models should be culturally and linguistically appropriate to all enrollees (Framework).
- **Physical Accessibility:**
  - "The State will ensure, using the facility site review tool, that each plan has physically accessible accommodations or contingency plans to meet the array of needs of all individuals who require accessible offices, examination or diagnostic equipment and other accommodations as a result of their disability or condition, and that they are advised of their obligations under the Americans with Disabilities Act and other applicable Federal statutes and rules regarding accessibility" (Waiver).

Appropriate & Accessible Care, Cont.

- **Interpreter Services/Information Technology**
  - "The State will ensure that each plan offers interpreter services for individuals who require assistance communicating, as a result of language barriers, disability, or condition. The State will ensure that each plan has capacity to utilize information technology including teleconferences and electronic options to ensure that delays in arranging services do not impede or delay an individual's timely access to care" (Waiver).
- **Transportation – Specialized**
  - "The State will ensure that each plan has non-emergency medical transportation available in sufficient supply and accessibility so that individuals have easily accessible and timely access for scheduled and unscheduled medical care appointments" (Waiver).

Beneficiary-Centered Care Models

- "The coordinated care delivery demonstration at every level should focus on the beneficiary" (Framework).
- The demonstration "should consider the need for beneficiaries to self-direct their care and be able to hire, fire and manage their personal care worker" (Framework).
- Delivery Models Should Include (Waiver):
  - Standardized Health Risk Assessments
  - Adequate Care Coordination
  - Individualized, Person-Centered Care Plans

Individualized Person-Centered Care Plans "At a Minimum" Should:

1. "Identify each enrollee's preferences, choices and abilities along with strategies to address those preferences, choices and abilities" (Waiver)
2. "Allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing" (Waiver)
3. "Ensure that the enrollee has informed choices about treatment and service decisions" (Waiver)
4. "Ensure the planning process will be collaborative, recurring and involve an ongoing commitment to the enrollee" (Waiver)
5. "Develop a process for identifying needs for and facilitating timely access to primary care, specialty care, durable medical equipment, medications, and other health services needed by the enrollee, including the need for referrals to resolve any physical or cognitive barriers to access" (Addendum).

Adequate Care Coordination

Demonstration of "Sufficient" Care Coordination includes:

- "Sufficient resources available to provide the full range of care coordination for individuals with disabilities, multiple and chronic conditions, and individuals who are aging" (Waiver).
- "Capacity to provide linkages to other necessary supports outside the plan's benefit package," such as:
  - "Mental health and behavioral health beyond the plan's benefits, personal care, housing, home delivered meals, energy assistance programs, and services for individuals with intellectual and developmental disabilities" (Waiver).
- "Care shall be coordinated across all settings including services outside the provider network" (Waiver).
- "Participating sites shall ensure the privacy of enrollee health records, and provide for access by enrollees to such records as specified in the contract" (Standards).

Oversight and Quality Monitoring Contd.

- CMS and DHCS “shall jointly conduct a single, comprehensive quality management process in accordance with Medicare Advantage and Medicaid managed care requirements” (MOU).
- CMS and DHCS “shall determine applicable quality standards and monitor the Participating Plan’s compliance with those standards” (MOU).
- “A rigorous evaluation” will include quality measures designed to ensure beneficiaries receive high quality care (MOU).

Creating Effective Two-Way Communication Between Sites and Beneficiaries

Meaningful Notice

- "Beneficiaries should be informed about enrollment rights and options, plan benefits and rules, and care plan elements with sufficient time to make informed choices" (Framework).
- Materials "shall be accessible and understandable" (MOU, Waiver, Standards)
  - Available in languages, formats and reading levels that will "substantially meet the needs" of dual eligibles enrolled in the demonstration (WAIVER).
  - Offers of individual assistance "should be prevalent" in all materials (Waiver).
- "An integrated model must provide enrollees with meaningful notices and other communications about, for example, enrollment rights and options, plan benefits and rules and care plan elements" *(NSCLC).*

Accessible Enrollee Communications

- All enrollee materials "shall require approval by CMS and the State prior to dissemination, and subject to a single set of rules" (MOU).
- Public communication tools (State-issued and State-directed from plans) should explain "every facet of enrollment, benefit packages, rights, safeguards and options to receive personal assistance with understanding the program and process" (Waiver).
- These materials at a minimum should include (MOU):
  - Outreach and education materials
  - Enrollment and disenrollment materials
  - Benefit coverage information
  - Operational letters for enrollment, disenrollment, claims or service denials, complaints, internal appeals, external appeals, and provider terminations.

Ensuring Proper Access and Delivery

Network Adequacy

- "CMS, the State and Participating Plans will ensure that beneficiaries have access to an adequate network of medical and supportive service providers that are appropriate and competent for the needs of this population" (MOU).
- "CMS and the State shall establish a process for Participating Plans to notify CMS and the State of all changes to its Provider Network and to provide a contingency plan for assuring continued access to care for enrollees in the case of a Participating Plan provider contract termination and/or insolvency of provider within a Participating Plan Provider Network" (MOU).
- "An integrated model must provide adequate access to providers who are able to serve the unique needs of dual eligibles," (NSCLC).
  - "Appropriate ratios of primary care providers with training in geriatrics to the population to be enrolled, an adequate specialist network including a sufficient number of specialists in diseases and conditions affecting the dual eligible population and a range of high quality nursing facility and home and community based provider options" (NSCLC).

Network Adequacy, Cont.

- "The State must ensure that each managed care entity has a provider network that is sufficient to provide access to all covered services … no later than 30 days prior to enrollment … and annually thereafter" (Waiver).
- "The State must through its health plans deliver adequate primary care, including care that is delivered in a culturally competent manner that is sufficient to provide access to covered services to the low-income population, and coordinate health care services for Demonstration populations" (Waiver).
- "The State must ensure that each managed care entity has a provider network that is sufficient to provide access to all covered services … no later than 30 days prior to enrollment … and annually thereafter" (Waiver).

Network Adequacy, Timeliness

- "The State through its health plans must comply with timely access requirements and ensure their providers comply with these requirements.
  - Providers must meet State standards for timely access to care and services, considering the urgency of the service needed.
  - Network providers must offer office hours at least equal to those offered to the health plan's commercial line of business enrollees or Medicaid fee-for-service participants, if the provider accepts only Medicaid patients.
  - Contracted services must be made available 24 hours per day, seven days per week when medically necessary.
  - The State, through the health plan contracts must establish mechanisms to ensure and monitor provider compliance and must take corrective action when noncompliance occurs" (Waiver).

Network Adequacy, Other

- **Out of Network Requirements** – "The State through its health plans must … adequately cover these benefits and services out of network in a timely fashion, for as long as it is necessary to provide them, at no additional cost to the enrollee" (Waiver).
- **Special Health Care Needs** – "Enrollees with special health care needs must have direct access to a specialist as appropriate for the individual's health care condition" (Waiver).
- **Credentialing** – "The State through its health plans must demonstrate that the health plan providers are credentialed. The State must also require these health plans to participate in efforts to promote culturally competent service delivery" (Waiver).

Beneficiary Oversight & Plan Responsiveness

- "Meaningful Beneficiary Input Process" may include:
  - Active participation on the site's governing boards and/or the establishment of a beneficiary advisory board (MOU, Standards).
- "The State shall assure that its enrollee services representatives can answer inquiries and respond to complaints and concerns" (MOU).
- "Demonstration sites shall employ customer service representatives who shall answer enrollee inquires and respond to complaints and concerns" (Standards)
- "Oversight must be comprehensive and coordinated to ensure that integrated models are performing contracted duties and delivering high quality services … Each integration model should have a process for soliciting and incorporating stakeholder input, such as stakeholder committees" (NSCLC).

Responsive, Integrated Appeals Process

- CMS and DHCS will "develop unified requirements for complaints and internal appeals processes that incorporate relevant Medicare Advantage, Medicare Part D and Medicaid managed care requirements" (MOU).
- Ensuring Access to grievance and appeals rights under Medicare and/or Medicaid.
  - "For the Capitated Model, this includes development of a unified set of requirements for Participating Plan complaints and internal appeals processes" (Standards).
  - "For the Managed FFS Model, the State will ensure a mechanism is in place for assisting the participant in choosing whether to pursue grievance and appeal rights under Medicare and/or Medicaid if both are applicable" (Standards).
- "Integrated Appeals Process should include: due process protections, clear notices in a language the enrollee can understand, coverage of care pending the appeal (referred to in Medicaid as "aid paid pending"), opportunities for expedited review, a path to a review by an independent decision maker and the right to appeal to an administrative law judge and, if necessary, federal court" (NSCLC).

Comprehensive Benefits

- The models should “ensure the provision and coordination of all necessary Medicare and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services” (Standards).
- “Coordinated care models have the potential to provide access to all necessary supports and services beneficiaries need and want. Financial incentives can then be aligned around keeping people in their homes and communities. Coordinated care models have the potential to increase the availability of and access to valued home and community based services” (Framework).

Launching the System

Beneficiary Choice: Enrollment

- "Choice begins with the decision to opt out of the demonstration at any time" (Framework).
- Disenrollment and transfers "shall be allowed on a month-to-month basis any time of the year throughout the entire duration of the initiative" (MOU).
- CMS and the State "shall develop and require the use of single enrollment and disenrollment documentation" (MOU).
- "Dual eligibles must have a right to choose how, where, and from whom they receive care. Choice begins with a truly voluntary, "opt in" enrollment model" (NSCLC).
- "Implementation should be phased" (NSCLC)
- "The demonstration should be phased in before expanding to all dual eligibles (Framework).

Standardized Health Risk Assessments

- Sites should develop "a risk stratification mechanism or algorithm for the purpose of identifying beneficiaries who have higher risk and more complex needs, and those who are at lower risk" (Addendum).
  - The mechanism must: "incorporate stakeholder and consumer input," be based historical FFS utilization and be validated against utilization data (Addendum).
- Risk Assessment Survey Tools
  - "Shall be used to comprehensively assess a member's current health risk" within 45 calendar days of enrollment for high-risk beneficiaries and within 105 days for lower-risk beneficiaries.
  - "Must include stakeholder and consumer input" (Addendum).
  - "Must be followed with a process to further stratify enrollees and inform the development of individualized, person-centered care plans" (Addendum).

Seamless Transitions & Care Continuity

- "The State shall ensure that the plans have mechanisms to provide continuity of care to SPD enrolled individuals in order to furnish seamless care with existing providers for a period of at least 12 months after enrollment and established procedures to bring providers into network" (Waiver).
- "The demonstration should develop policies and procedures to ensure smooth care transitions" (Framework).
- "There must be continuity of care, allowing access to current providers and services, treatments and drug regimes during the transition process" *(NSCLC)*.
- The State "shall provide documentation that information technology systems and infrastructure are in place that can effectively manage the data exchange needed to support a smooth transition" (Waiver).